## ATTACHMENT 5

## Sample CMS 1500 claim form for school-based services

TTPICA	L	IEAI TH ING	SURANCE CLAIM	FORM		
. MEDICARE MEDICAID CHAMPUS CHAMPVA				1.071		
	HEALTH PLAN BL	KLUNG	1a. INSURED'S I.D. NUMBER	(FOR PROGRAM IN ITEM 1)		
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #)		SSN) (ID)	123456789			
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM   DD   YY	SEX	4. INSURED'S NAME (Last Nar	me, First Name, Middle Initial)		
Recipient, Ima A.	MM   DD   YYYY M					
i. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No.,	Street)		
	Self Spouse Child Other					
CITY STATE I	8. PATIENT STATUS		CITY	STATE		
	Single Married	Other	[			
IP CODE TELEPHONE (Include Area Code)	• 🗀		ZIP CODE	TELEPHONE (INCLUDE AREA CODE)		
$1 \leftarrow 1$	Employed Full-Time	Part-Time		( )		
D. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION	Student	11. INSURED'S POLICY GROU	IN OR SECONDUCTOR		
. OTHER MODILE O NAME (East Name, First Name, Middle Mittal)	10. IS PATIENT 3 CONDITION	TRELATED TO:	11. INSURED'S POLICY GROU	IP OR FECA NUMBER		
I. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)		a. INSURED'S DATE OF BIRTH SEX			
	YES NO		M F			
	b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER'S NAME OR SO	HOOL NAME		
MM DD YY	YES	NO i				
. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME O	R PROGRAM NAME		
	YES	□NO				
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
The state of the s	ALGERTED I ON LOOKE					
DEAD DAOK OF FORM REFERENCE AND A STATE OF THE STATE OF T			YES NO	If yes, return to and complete item 9 a-d.		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for				
to process this claim. I also request payment of government benefits either to	myself or to the party who acce	epts assignment	services described below.	to the direct signed physician or supplier for		
below.						
SIGNEDDATE		SIGNED				
4. DATE OF CURRENT:   #ILLNESS (First symptom) OR 15. IF	PATIENT HAS HAD SAME OF	R SIMILAR ILLNESS.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION			
MM   DD   YY   INJURY (Accident) OR   GI	IVE FIRST DATE MM   DD	YY	MM DD YY	TO MM   DD   YY		
	.D. NUMBER OF REFERRING	PHYSICIAN		RELATED TO CURRENT SERVICES		
19. RESERVED FOR LOCAL USE  21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)  1. L999.9  3. L		MM DD YY	MM ; DD ; YY			
		FROM TO  20. OUTSIDE LAB? \$ CHARGES				
					YES NO	
		22. MEDICAID RESUBMISSION ORIGINAL REF. NO.				
					23. PRIOR AUTHORIZATION NUMBER	
		9.1	1			
		2 4. 4. A B C	D	1 E	F G	ніі і і к
DATE(S) OF SERVICE Place Type PROCEDURE	S, SERVICES, OR SUPPLIES	DIAGNOSIS	DAYS	EPSDT BESERVED FOR		
MM DD YY MM DD YY Service CPT/HCPCS	Unusual Circumstances) MODIFIER	CODE	\$ CHARGES OR UNITS	Family Plan EMG COB LOCAL USE		
	_ 1					
1 03 03 05 07 03 97110	O   TM; GP	1	XX XX 6.0			
1 06 03   03   92506	6   TM	1	XX XX 1.5			
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5. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACC	COUNT NO. 27, ACCEP	T ASSIGNMENT?	28. TOTAL CHARGE 29	AMOUNT PAID 30, BALANCE DUE		
	(For gov	rt. ciaims, see back)				
☐ ☐ 1234JEC	(For gov	□ NO	s XX XX s	0 00 s XX XX		
1. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND AD INCLUDING DEGREES OR CREDENTIALS 32. NAME AND AD MENDERED (IF	(For gov	□ NO	s XX XX s			
1. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse)	(For gov YES DRESS OF FACILITY WHERE	□ NO	\$ XX XX \$ 33. PHYSICIAN'S, SUPPLIER'S & PHONE #	0 00 s XX XX		
1. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	(For gov YES DRESS OF FACILITY WHERE	□ NO	\$ XX XX \$ 33. PHYSICIAN'S, SUPPLIER'S & PHONE # 1.M. Billing	0 00 s XX XX		
1. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse)	(For gov YES DRESS OF FACILITY WHERE	□ NO	\$ XX XX \$ 33. PHYSICIAN'S, SUPPLIER'S & PHONE #	0 00 s XX XX BILLING NAME, ADDRESS, ZIP CODE		